STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155139	A. BUILDING 00 B. WING	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WOODS VILLAGE	2233 W JEFFERSON ST KOKOMO, IN 46901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the investigation of Complaints IN00104295 and IN00104351. Complaint IN00104295 - Substantiated, Federal deficiencies related to the allegation are cited at F-223, F-225. and F-226. Complaint IN00104351 - Substantiated, Federal deficiency related to the allegation are cited at F-282 and F-323. Survey dates: February 29 and March 1, 2012 Facility number: 000064 Provider number: 155139 AIM number: 100288770 Survey team: DeAnn Mankell, RN, TC Shelley Reed, RN Census bed type: SNF: 16 SNF/NF: 136 Total: 152 Census payor type: Medicare: 31 Medicaid: 92	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Other: 29 Total: 152 Sample: 5 Supplemental Sample: 5 These deficiencies also reflect state finding cited in accordance with 410 IAC 16.2. Quality review completed 3/6/12 Cathy Emswiller RN			

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F0223 SS=D	483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to ensure a resident was from verbal abuse for 1 of 5 residents in a sample of 5 reviewed for abuse. (Resident D) Findings include: 1. During an interview on 2/29/12 at 9:50 a.m., Resident D indicated someone came into her room after she had her call light on for awhile. The staff member indicated the call light was not on outside and proceeded to adjust call light to make sure it was working properly. The resident indicated the staff member then stood over her and said "hit me right there" while pointing to her own cheek. The resident replied "don't tempt me". The resident said she had never seen the staff member before. The resident reported the incident the following day to the ADON. During record review on 2/29/12 at 2:30	F0223	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after March 26, 2012. **F 223 Free From Abuse/Involuntary Seclusion** It is the practice of this provider to ensure the residents have the right to be free from verbal,	03/26/2012

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	p.m., the minimum data set (MDS) assessment dated 2/3/12, indicated the resident had a brief interview mental status (BIMS) score 14 of 15. This BIMS score on the MDS indicated the resident was reliable and interviewable. Resident D's diagnoses included, but not limited to, multiple sclerosis, encephalopathy, and depression. During an interview on 2/29/12 at 10:45 a.m., the ADON indicated she was called into Resident D's room on 2/20/12 at 1:00 p.m. The resident indicated her call light was on for more than one hour at 1:00 a.m. on 2/20/12 before being answered. The resident said a nurse had entered her room and she asked for ice. The resident indicated the nurse left and did not come back so she placed the call light on again. The nurse entered her room again and resident was yelling at the nurse. The resident indicated the nurse leaned in close to her face and dared the resident to hit her. The resident stated to the ADON she was unsure of who the nurse was but gave a description of the staff member in her room. During an interview on 2/29/12 at 11:15 a.m., Social Service #3 indicated she met with the resident following the allegation of verbal abuse on 2/20/12 at 10:53 a.m.		sexual, physical, and mental abuse, corporal punishment and involuntary seclusion. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident D interviewed and Social Service assessment were performed with no negative outcome. · LPN #2 interviewed along with 2 witnesses, incident was unsubstantiated LPN #2 given compassionate caregiver on 2-21-12 by the Assistant Director of Nursing (ADNS) . **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents in the facility have the potential to be affected by the alleged deficient practice. · Other Residents in the facility were interviewed and no concerns were voiced · Nursing staff will be re-educated on alleged abuse, investigations and reporting appropriately including notifiying Executive Director (ED) immediately of any allegation of abuse, neglect or misappropriation of property by 3-23-12 by the SDC/designee. If ED is not notified appropriate disciplinary action will be taken up to and including termination. **What measures will be put into place**	

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	Resident D restated the incident to social service. The resident stated she was nervous but going about her daily routine. Social service #3 indicated the resident did not have a history of making allegations and she was surprised by the verbal abuse allegation. During review of the investigation report of alleged abuse on 2/29/12 at 10:45 a.m., the report indicated on 2/20/12 at 1:00 p.m., Resident D reported to the Assistant Director of Nursing (ADON) at 1:00 a.m., on 2/20/12 that LPN #2 came into her room after resident placed call light on and moved close to resident's face and said "hit me right there" and pointed to LPN #1's chin. The ADON's investigation indicated she had interviewed 5 residents, identified as Residents F, G, H, I, and J, who reside in the same hall where the incident took place, regarding safety and abuse. During the interview, the ADON indicated that LPN #2 who was identified as the staff member involved in the incident did not work in the area of the incident and she should have interviewed residents who reside in the area where LPN #2 worked. On February 29, 2012 at 9:00 a.m., the Administrator provided a policy entitled, "Abuse Prohibition, Reporting, and		**or what systemic changes you will make to ensure that the deficient practice does not recur** · Staff will be re-educated by 3-23-12 by the SDC/designee on Abuse policy being followed, proper reporting and investigations of alleged abuse. · Investigation was completed and the nurse #2 was given compassionate caregiver training on 2-21-12 by Assistant Director of Nursing (ADNS) · Staff was educated on proper reporting alleged abuse and investigation 3-6-12 and by 3-23-12 by SDC/Designee. · Staff report allegations of abuse, to their immediate supervisor. The Executive Director and/or Director of Nursing Services is notified and initiate the report to the appropriate regulatory agencies. Including notifiying ED immediately of any allegation of abuse, neglect or misappropriation of propery. If ED is not notified appropriate disciplinary action will be taken up to and including termination. · Residents who have an alleged abuse will have a complete investigation initiated and residents throughout the facility will be interviewed to determine if abuse has occurred and if residents feel safe. · This investigation will include interviews of staff, other residents, and family members if necessary. · Physician and family will be notified of	

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	Infestation," with a review date of February 2010. This policy indicated, "....11. The investigation will include: Facts and observations from others who might have pertinent information...." This Federal tag relates to complaint #IN00104295 3.1-27(b)		allegations of abuse as needed. · Employees that are implicated in an allegation of abuse are removed from the schedule, to ensure resident safety, until the investigation is completed. · The interdisciplinary team will review the “24 Hour Report” and “Change of Condition” forms for physician and family notification Monday – Friday (excluding holidays) at clinical meeting. · Employees will have a criminal history check upon hire. · Employees will receive abuse prevention training upon hire and at least annually thereafter. · The nursing manager on call is notified of acute resident changes on the weekend. DNS/ED is notified as needed. · The Executive Director/Designee is responsible for compliance with the Abuse Policy and Procedure and the reporting of allegations of abuse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The CQI tool “Staff Treatment of Residents” will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. · The DNS or designee is responsible to monitor for compliance. · The CQI team reviews the audits monthly and action plans are	

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			developed if threshold of 100% is not achieved to ensure continual compliance. **Compliance date: March 26, 2012**	

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F0225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly	F0225	**F 225**	03/26/2012

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	investigate the allegation of abuse for 1 of 5 residents in a sample of 5 reviewed for abuse. (Resident D) Findings include: During review of the investigation report of alleged abuse on 2/29/12 at 10:45 a.m.,the investigation indicated on 2/20/12 at 1:00 p.m., Resident D reported to the Assistant Director of Nursing (ADON) at 1:00 a.m., on 2/20/12, that LPN #2 came into her room after the resident placed call light on and moved close to resident's face and said, "hit me right there," and pointed to LPN #1's chin. During interview on 2/12/12 at 10:45 a.m., the ADON indicated she interviewed 5 residents, Resident's F, G, H, I, and J, who reside in the same hall where the incident took place, regarding safety and abuse. During the interview, the ADON indicated that LPN #2 who was identified as the staff member involved in the incident did not work in the area of the incident and she should have interviewed residents who reside in the area where LPN #2 worked. This Federal tag relates to complaint #IN00104295 3.1-28(d)		**Investigate/Report allegation/individuals** It is the practice of this provider to ensure alleged violations involving mistreatment, neglect, or abuse are reported immediately to administration of the facility and appropriate investigation and corrective action taken. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident D interviewed and Social Service assessment were performed with no negative outcome. · LPN #2 interviewed along with 2 witnesses, incident was unsubstantiated LPN #2 given compassionate caregiver on 2-21-12 by ADNS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents in the facility have the potential to be affected by the alleged deficient practice. · Other Residents in the facility were interviewed and no concerns were voiced · Nursing staff will be re-educated on alleged abuse, investigations and	

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			reporting appropriately including notifying ED immediately of any allegation of abuse, neglect or misappropriation of property by 3-23-12 by the SDC/designee. If ED is not notified appropriately, disciplinary action will be taken up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Staff will be re-educated by 3-23-12 by the SDC/designee on Abuse policy being followed, proper reporting and investigations of alleged abuse. · Investigation was completed and the nurse #2 was given compassionate caregiver training on 2-21-12 by Assistant Director of Nursing (ADNS) · Staff was educated on proper reporting alleged abuse and investigation 3-6-12 and by 3-23-12 by SDC/Designee. · Staff report allegations of abuse, to their immediate supervisor. The Executive Director and/or Director of Nursing Services is notified and initiate the report to the appropriate regulatory agencies. Including notifying ED immediately of any allegation of abuse, neglect, or misappropriation of property. If ED is not notified appropritate disciplinary action will be taken up to and including termination. · Residents who have an alleged abuse will have a complete	

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			investigation initiated and residents throughout the facility will be interviewed to determine if abuse has occurred and if residents feel safe. · This investigation will include interviews of staff, other residents, and family members if necessary. · Physician and family will be notified of allegations of abuse as needed. · Employees that are implicated in an allegation of abuse are removed from the schedule, to ensure resident safety, until the investigation is completed. · The interdisciplinary team will review the "24 Hour Report" and "Change of Condition" forms for physician and family notification Monday – Friday (excluding holidays) at clinical meeting. · Employees will have a criminal history check upon hire. · Employees will receive abuse prevention training upon hire and at least annually thereafter. · The nursing manager on call is notified of acute resident changes on the weekend. DNS/ED is notified as needed. · The Executive Director/Designee is responsible for compliance with the Abuse Policy and Procedure and the reporting of allegations of abuse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place** · The CQI tool "Staff Treatment of Residents"	

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			will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. · The DNS or designee is responsible to monitor for compliance. · The CQI team reviews the audits monthly and action plans are developed if a threshold of 100% is not achieved to ensure continual compliance. **Compliance date: March 26, 2012**	

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F0226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on interview and record review, the facility failed to correctly follow policies and procedures for investigating abuse for 1 of 5 residents in a sample of 5 reviewed for abuse. (Resident D) Findings include: During review of the investigation report of the alleged abuse on 2/29/12 at 10:45 a.m., indicated on 2/20/12 at 1:00 p.m., Resident D reported to the Assistant Director of Nursing (ADON) at 1:00 a.m., on 2/20/12 that LPN #2 came into her room after resident placed her call light on and moved close to resident's face and said "hit me right there" and pointed to LPN #1's chin. During interview on 2/12/12 at 10:45 a.m., the ADON indicated she interviewed 5 residents, Residents F, G, H, I, and J, who reside in the same hall where the incident took place, regarding safety and abuse . During the interview, the ADON indicated that LPN #2 who was identified as the staff member	F0226	**F226 Develop/Implement Abuse/Neglect, ETC Policies** It is the practice of this provider to follow all written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice** · Resident D interviewed and Social Service assessment were performed with no negative outcome. · LPN #2 interviewed along with 2 witnesses, incident was unsubstantiated LPN #2 given compassionate caregiver on 2-21-12 by ADNS. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · Residents in the facility have the potential to be affected by the alleged deficient practice. · Other Residents in the facility were interviewed and no concerns were voiced · Nursing staff will be re-educated on	03/26/2012

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	involved in the incident did not work in the area of the incident and she should have interviewed residents who resided in the area where LPN #2 worked. On February 29, 2012 at 9:00 a.m., the Administrator provided a policy entitled, "Abuse Prohibition, Reporting, and Infestation," with a review date of February 2010. This policy indicated, "....11. The investigation will include: Facts and observations from others who might have pertinent information...." This Federal tag relates to complaint #IN00104295 3.1-28(a)		alleged abuse, investigations and reporting appropriately including notifying Executive Director (ED) immediately of any allegation of abuse, neglect, or misappropriation of property by 3-23-12 by the SDC/designee. If ED is not notified appropriately disciplinary action will be taken up to and including termination. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Staff will be re-educated by 3-23-12 by the SDC/designee on Abuse policy being followed, proper reporting and investigations of alleged abuse. · Investigation was completed and the nurse #2 was given compassionate caregiver training on 2-21-12 by Assistant Director of Nursing (ADNS) · Staff was educated on proper reporting alleged abuse and investigation 3-6-12 and by 3-23-12 by SDC/Designee. · Staff report allegations of abuse, to their immediate supervisor. The Executive Director and/or Director of Nursing Services is notified and initiate the report to the appropriate regulatory agencies. Including notifying ED immediately of any allegation of abuse, neglect, or misappropriation of property. If ED is not notified appropriately disciplinary action will be taken up to and including termination. ·	

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			Residents who have an alleged abuse will have a complete investigation initiated and residents throughout the facility will be interviewed to determine if abuse has occurred and if residents feel safe. · This investigation will include interviews of staff, other residents, and family members if necessary. · Physician and family will be notified of allegations of abuse as needed. · Employees that are implicated in an allegation of abuse are removed from the schedule, to ensure resident safety, until the investigation is completed. · The interdisciplinary team will review the “24 Hour Report” and “Change of Condition” forms for physician and family notification Monday – Friday (excluding holidays) at clinical meeting. · Employees will have a criminal history check upon hire. · Employees will receive abuse prevention training upon hire and at least annually thereafter. · The nursing manager on call is notified of acute resident changes on the weekend. DNS/ED is notified as needed. · The Executive Director/Designee is responsible for compliance with the Abuse Policy and Procedure and the reporting of allegations of abuse. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	155139	A. BUILDING 00 B. WING	03/01/2012

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			into place · The CQI tool "Staff Treatment of Residents" will be utilized by the Interdisciplinary Team weekly for four weeks, monthly for three months, and quarterly until compliance is achieved for two consecutive quarters. · The DNS or designee is responsible to monitor for compliance. · The CQI team reviews the audits monthly and action plans are developed if threshold of 100% is not achieved to ensure continual compliance. **Compliance date: March 26, 2012**	

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure 2 or more staff transferred the resident to prevent a laceration to a resident's lower left leg, during at transfer, resulting in a visit to the emergency room where sutures were placed in a jagged laceration for 1 of 3 residents with falls in a sample of 5 (Resident C). Findings included: 1. During the facility tour with the Unit Manager on 2/29/12 at 8:30 A.M., Resident C was identified was having a hematoma on her leg that had opened which required sutures. Resident C's clinical record was reviewed on 2/29/12 at 9:50 A.M. Resident C's diagnoses included, but were not limited to chronic encephalopathy, hypothyroidism, anemia, bipolar, depression, renal failure, malnutrition, and failure to thrive (FTT). Resident C's Admission MDS (minimum	F0282	**F282 Services by Qualified Persons Per Care Plan** It is the practice of this provider to ensure services are provided or arranged by the facility by qualified persons in accordance with the written plan of care. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident C's MDS, Care Plan and resident need sheet was audited to ensure appropriate transfer information was correct. · Resident C is now being transferred with assist of 2. · Certified Nursing Assistant (C.N.A) was immediately given verbal counseling on proper transfers and the use of the resident need sheet on 2-18-2012 by the nurse manager. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken**	03/26/2012

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	data set) assessment completed on 2/18/12 indicated Resident C's cognitive status was assessed with a BIMS (brief interview for mental status) with a score of 4/15, which indicated the resident had severe cognitive impairment. Her functional status was assessed as extensive assistance of two+ persons for transfers from the wheelchair to the bed. She was assessed as not steady with transfers. The occupational therapy notes dated 2/15/12 indicated the resident needed "Max assist x's 2 to sit to stand in bar (parallel type bars)." The physical therapy notes dated 2/15/12 indicated the resident "...needed assist x 3 to sit down in wc (wheelchair) behind her." The Care Plan dated 2/11/12 for the problem of "Fall risk related to: recieves (sic) cardiac and psychotropic medications, needs extensive assist for transfer and toileting." The approaches included but were not limited to, "....Provide assistance as needed...." The progress notes dated 2/18/12 at 7:17 P.M., indicated "Writer was called into residents (sic) room by son stating "my mom is bleeding, please come help us."		· All Resident's MDS, Care Plan and resident need sheets were audited to ensure appropriate transfer information was correct. · Nursing staff will be re-educated on following MDS, Care Plan and need sheets for resident transfers by the SDC or designee by 3-23-2012. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** · All Resident's MDS, Care Plan and resident need sheets were audited to ensure appropriate transfer information was correct. · Nursing staff will be re-educated on following MDS, Care Plan and need sheets for resident transfers by the SDC or designee by 3-23-2012. · Nursing Management staff will make rounds daily on all shifts to ensure residents are transferred per care plan. · Upon admission and during the Care Plan review process, Care Plans, MDS and need sheets will be reviewed to ensure appropriateness for each resident. **How the corrective action(s) will be monitored to ensure the**	

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	writer (sic) went into room to find a huge "L" shaped jagged edge of her LLE (left lower extremity) cut open and bleeding. approx (sic) area to be measured 33 cm (centimeters). resident (sic) had approx +2 pitting edema on BLE. area (sic) cleaned with water. areas (sic) was seaping (sic) with blood. no (sic) c/o (complaints of) SOB (short of breath) noted. resident (sic) has mild c/o pain at L leg. aid (sic) was helping get resident to bed with a nice gentle transfer, and noticed bleeding. area (sic) around wound has purple bruising noted. family (sic) in room...." Resident C was transferred to the Emergency Room on 2/18/12 at 8:03 P.M. The emergency room notes indicated the resident was a "high fall risk," had dementia, swelling to her left lower leg, and had a laceration to the left lower leg that was a jagged and measured 9 centimeters. The emergency room physician sutured the laceration closed. During an interview with the ADON (Assistant Director of Nurses) on 2/29/12 at 1:40 P.M., she indicated the DON had told her the skin tear had occurred during the resident transfer. During a follow-up interview with the ADON on 2/29/12 at 1:50 P.M., she indicated the supervisor in the building that night had talked with the		**deficient practice will not recur? i.e., what quality assurance program will be put into place** · The CQI tool "C.N.A Resident Care" will be completed weekly for four weeks, monthly for three months, and then quarterly until compliance is maintained for two consecutive quarters. · The CQI Team will review the data. If the threshold of 100% for compliance is not met then an action plan will be developed. **Compliance date: March 26, 2012**	

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	CNA and told her she needed to have assistance with another CNA helping her to transfer the resident. Review of an undated written statement made by CNA #4, provided by the DON on 3/1/12 at 8:30 A.M., indicated "I was educated after incident occurred c (with) hematoma to residents (L) (left) lower leg to always have two people during transfers @ all times." Review of the undated Resident Care Sheet provided on 2/29/12 at 1:45 P.M., indicated Resident C was dependent for transfers and needed the assistance of 2 staff members to transfer her. This form had geri-gloves and geri-sleeves were to be placed on the resident to help prevent skin tears. Review of an undated guideline provided by the ADON on 3/1/12 at 12:49 P.M., for "Accidents" indicated "Implement interventions to reduce hazard(s) and risk(s), including adequate supervision (observation and timely intervention by the facility and its staff to prevent or reduce likelihood of a accident), consistent with the resident's needs, goals, plan of care, and recognized standards of practice...." This Federal tag relates to complaint #			

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	IN00104351. 3.1-45(a)(2)			

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F0323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure 2 or more staff transferred the resident to prevent a laceration to a resident's lower left leg, during at transfer, resulting in a visit to the emergency room where sutures were placed in a jagged laceration for 1 of 3 residents with falls in a sample of 5 (Resident C). Findings included: 1. During the facility tour with the Unit Manager on 2/29/12 at 8:30 A.M., Resident C was identified was having a hematoma on her leg that had opened which required sutures. Resident C's clinical record was reviewed on 2/29/12 at 9:50 A.M. Resident C's diagnoses included, but were not limited to chronic encephalopathy, hypothyroidism, anemia, bipolar, depression, renal failure, malnutrition, and failure to thrive (FTT).	F0323	**F323 Free of Accident Hazards/Surpervision/Devices** It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resident C's MDS, Care Plan and resident need sheet was audited to ensure appropriate transfer information was correct. · Resident C is now being transferred with assist of 2. · Certified Nursing Assistant (C.N.A) was immediately given verbal counseling on proper transfers and the use of the resident need sheet on 2-18-2012 by the nurse manager.	03/26/2012

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	Resident C's Admission MDS (minimum data set) assessment completed on 2/18/12 indicated Resident C's cognitive status was assessed with a BIMS (brief interview for mental status) with a score of 4/15, which indicated the resident had severe cognitive impairment. Her functional status was assessed as extensive assistance of two+ persons for transfers from the wheelchair to the bed. She was assessed as not steady with transfers. The occupational therapy notes dated 2/15/12 indicated the resident needed "Max assist x's 2 to sit to stand in bar (parallel type bars)." The physical therapy notes dated 2/15/12 indicated the resident "...needed assist x 3 to sit down in wc (wheelchair) behind her." The Care Plan dated 2/11/12 for the problem of "Fall risk related to: recieves (sic) cardiac and psychotropic medications, needs extensive assist for transfer and toileting." The approaches included but were not limited to, "....Provide assistance as needed...." The progress notes dated 2/18/12 at 7:17 P.M., indicated "Writer was called into residents (sic) room by son stating "my		**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** · All Resident's MDS, Care Plan and resident need sheets were audited to ensure appropriate transfer information was correct. · Nursing staff will be re-educated on following MDS, Care Plan and need sheets for resident transfers by the SDC or designee by 3-23-2012. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** · All Resident's MDS, Care Plan and resident need sheets were audited to ensure appropriate transfer information was correct. · Nursing staff will be	

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	mom is bleeding, please come help us." writer (sic) went into room to find a huge "L" shaped jagged edge of her LLE (left lower extremity) cut open and bleeding. approx (sic) area to be measured 33 cm (centimeters). resident (sic) had approx +2 pitting edema on BLE. area (sic) cleaned with water. areas (sic) was seaping (sic) with blood. no (sic) c/o (complaints of) SOB (short of breath) noted. resident (sic) has mild c/o pain at L leg. aid (sic) was helping get resident to bed with a nice gentle transfer, and noticed bleeding. area (sic) around wound has purple bruising noted. family (sic) in room...." Resident C was transferred to the Emergency Room on 2/18/12 at 8:03 P.M. The emergency room notes indicated the resident was a "high fall risk," had dementia, swelling to her left lower leg, and had a laceration to the left lower leg that was a jagged and measured 9 centimeters. The emergency room physician sutured the laceration closed. Review of the emergency room report dated 2/18/2012 at 8:05 P.M., indicated Resident C had a 9 centimeter laceration to her left lower leg with a small amount of bleeding noted. The left leg laceration was stitched per the physician and steri strips were applied with an ACE bandage		re-educated on following MDS, Care Plan and need sheets for resident transfers by the SDC or designee by 3-23-2012. · Nurse Management staff will make rounds daily on all shifts to ensure all residents are transferred per care plan. · Upon admission and during the Care Plan review process, Care Plans, MDS and need sheets will be reviewed to ensure appropriateness for each resident. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place** · The CQI tool "C.N.A Resident Care" will be completed weekly for four weeks, monthly for three months, and then quarterly until compliance is maintained for two consecutive quarters. · The CQI Team will review the data. If the threshold of 100% for compliance is not met then an action plan will be developed.	

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	applied to the left lower leg. Resident C was discharged back to the facility. The progress notes dated 2/18/12 at 9:25 P.M., indicated "res returned from ER via (name of ambulance service) has a running suture to LLE skin tear with steri strips and ace wrap...." During an interview with the ADON (Assistant Director of Nurses) on 2/29/12 at 1:40 P.M., she indicated the DON had told her the skin tear had occurred during the resident transfer. During a follow-up interview with the ADON on 2/29/12 at 1:50 P.M., she indicated the supervisor in the building that night had talked with the CNA and told her she needed to have assistance with another CNA helping her to transfer the resident. Review of an undated written statement made by CNA #4, provided by the DON on 3/1/12 at 8:30 A.M., indicated "I was educated after incident occurred c (with) hematoma to residents (L) (left) lower leg to always have two people during transfers @ all times." Review of the undated Resident Care Sheet provided on 2/29/12 at 1:45 P.M., indicated Resident C was dependent for transfers and needed the assistance of 2 staff members to transfer her. This form		**Compliance date: March 26, 2012**	

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	had geri-gloves and geri-sleeves were to be placed on the resident to help prevent skin tears. Review of an undated guideline provided by the ADON on 3/1/12 at 12:49 P.M., for "Accidents" indicated "Implement interventions to reduce hazard(s) and risk(s), including adequate supervision (observation and timely intervention by the facility and its staff to prevent or reduce likelihood of a accident), consistent with the resident's needs, goals, plan of care, and recognized standards of practice...." This Federal tag relates to complaint # IN00104351. 3.1-45(a)(2)			